Complete Summary

GUIDELINE TITLE

Counseling and interventions to prevent tobacco use and tobacco-caused disease in adults and pregnant women: U.S. Preventive Services Task Force reaffirmation recommendation statement.

BIBLIOGRAPHIC SOURCE(S)

U.S. Preventive Services Task Force. Counseling and interventions to prevent tobacco use and tobacco-caused disease in adults and pregnant women: U.S. Preventive Services Task Force reaffirmation recommendation statement. Ann Intern Med 2009 Apr 21;150(8):551-5. [7 references] PubMed

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: U.S. Preventive Services Task Force (USPSTF). Counseling to prevent tobacco use and tobacco-caused disease: recommendation statement. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2003 Nov. 13 p.

** REGULATORY ALERT **

FDA WARNING/REGULATORY ALERT

Note from the National Guideline Clearinghouse: This guideline references a drug(s)/intervention(s) for which important revised regulatory and/or warning information has been released.

- July 1, 2009 - Chantix or Champix (Varenicline) and Zyban or Wellbutrin (bupropion or amfebutamone): The U.S. Food and Drug Administration (FDA) notified healthcare professionals and patients that it has required the manufacturers of the smoking cessation aids varenicline (Chantix) and bupropion (Zyban and generics) to add new Boxed Warnings and develop patient Medication Guides highlighting the risk of serious neuropsychiatric symptoms in patients using these products. These symptoms include changes in behavior, hostility, agitation, depressed mood, suicidal thoughts and behavior, and attempted suicide.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

- Tobacco use
- Tobacco-caused diseases

GUIDELINE CATEGORY

Counseling
Prevention
Screening
Treatment

CLINICAL SPECIALTY

Family Practice
Internal Medicine
Obstetrics and Gynecology
Preventive Medicine

INTENDED USERS

Advanced Practice Nurses
Nurses
Physician Assistants
Physicians
Public Health Departments

GUIDELINE OBJECTIVE(S)

- To summarize the U.S. Preventive Services Task Force (USPSTF) recommendations and supporting evidence on counseling to prevent tobacco use and tobacco-caused disease
- To reaffirm the 2003 recommendations on counseling to prevent tobacco use and tobacco-caused disease

TARGET POPULATION

Adults 18 years or older and all pregnant women regardless of age

Note: The U.S. Preventive Services Task Force (USPSTF) plans to issue a separate recommendation statement about counseling to prevent tobacco use in nonpregnant adolescents and children.

INTERVENTIONS AND PRACTICES CONSIDERED

Screening

Screening for tobacco use

Tobacco Cessation Interventions

1. Counseling and patient education, including:
    - "5-A" behavioral counseling framework (ask, advise, assess, assist, arrange)
    - Augmented pregnancy-tailored counseling
    - Self-help materials
    - Problem-solving guidance
    - Provision of social support

    Note: Complementary practices that improve cessation rates include motivational interviewing, assessing readiness to change, offering more intensive counseling or referrals, and using telephone quit lines.

2. Pharmacotherapy, including:
    - Nicotine replacement therapy (i.e., gum, lozenge, transdermal patches, inhaler, and nasal spray)
    - Sustained-release bupropion
    - Varenicline

MAJOR OUTCOMES CONSIDERED

- Quit rates
- Abstinence rates

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

In 2003, the U.S. Preventive Services Task Force (USPSTF) reviewed the evidence for tobacco cessation interventions in adults and pregnant women contained in the 2000 Public Health Service (PHS) clinical practice guideline "Treating Tobacco Use and Dependence" and found that the benefits of these interventions substantially outweighed the harms. In 2008, the USPSTF reviewed new evidence in the PHS guideline and determined that the net benefits of screening and tobacco cessation interventions in adults and pregnant women remain well established. The USPSTF

found no new substantial evidence that could change its recommendations and, therefore, reaffirms its previous recommendations. The previous recommendation statement and a link to the updated PHS guideline review can be found at www.preventiveservices.ahrq.gov.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review
Review of Published Meta-Analyses

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Balance Sheets
Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The U.S. Preventive Services Task Force (USPSTF) systematically reviews the evidence concerning both the benefits and harms of widespread implementation of a preventive service. It then assesses the certainty of the evidence and the magnitude of the benefits and harms. On the basis of this assessment, the USPSTF assigns a letter grade to each preventive service signifying its recommendation about provision of the service (see Table below). An important, but often challenging, step is determining the balance between benefits and harms to estimate "net benefit" (that is, benefits minus harms).

Table 1. U.S. Preventive Services Task Force Recommendation Grid*

Certainty of Net Benefit	Magnitude of Net Benefit			
	Substantial	Moderate	Small	Zero/Negative
High	A	B	C	D
Moderate	B	B	C	D

Certainty of Net Benefit	Magnitude of Net Benefit			
	Substantial	Moderate	Small	Zero/Negative
Low	Insufficient			

**A*, *B*, *C*, *D*, and *I (Insufficient)* represent the letter grades of recommendation or statement of insufficient evidence assigned by the U.S. Preventive Services Task Force after assessing certainty and magnitude of net benefit of the service (see the "Rating Scheme for the Strength of the Recommendations" field).

The overarching question that the Task Force seeks to answer for every preventive service is whether evidence suggests that provision of the service would improve health outcomes if implemented in a general primary care population. For screening topics, this standard could be met by a large randomized, controlled trial (RCT) in a representative asymptomatic population with follow-up of all members of both the group "invited for screening" and the group "not invited for screening."

Direct RCT evidence about screening is often unavailable, so the Task Force considers indirect evidence. To guide its selection of indirect evidence, the Task Force constructs a "chain of evidence" within an analytic framework. For each key question, the body of pertinent literature is critically appraised, focusing on the following 6 questions:

1. Do the studies have the appropriate research design to answer the key question(s)?
2. To what extent are the existing studies of high quality? (i.e., what is the internal validity?)
3. To what extent are the results of the studies generalizable to the general U.S. primary care population and situation? (i.e., what is the external validity?)
4. How many studies have been conducted that address the key question(s)? How large are the studies? (i.e., what is the precision of the evidence?)
5. How consistent are the results of the studies?
6. Are there additional factors that assist us in drawing conclusions (e.g., presence or absence of dose–response effects, fit within a biologic model)?

The next step in the Task Force process is to use the evidence from the key questions to assess whether there would be net benefit if the service were implemented. In 2001, the USPSTF published an article that documented its systematic processes of evidence evaluation and recommendation development. At that time, the Task Force's overall assessment of evidence was described as good, fair, or poor. The Task Force realized that this rating seemed to apply only to how well studies were conducted and did not fully capture all of the issues that go into an overall assessment of the evidence about net benefit. To avoid confusion, the USPSTF has changed its terminology. Whereas individual study quality will continue to be characterized as good, fair, or poor, the term *certainty* will now be used to describe the Task Force's assessment of the overall body of evidence about net benefit of a preventive service and the likelihood that the assessment is correct. Certainty will be determined by considering all 6 questions listed above; the judgment about certainty will be described as high, moderate, or low.

In making its assessment of certainty about net benefit, the evaluation of the evidence from each key question plays a primary role. It is important to note that the Task Force makes recommendations for real-world medical practice in the United States and must determine to what extent the evidence for each key question—even evidence from screening RCTs or treatment RCTs—can be applied to the general primary care population. Frequently, studies are conducted in highly selected populations under special conditions. The Task Force must consider differences between the general primary care population and the populations studied in RCTs and make judgments about the likelihood of observing the same effect in actual practice.

It is also important to note that 1 of the key questions in the analytic framework refers to the potential harms of the preventive service. The Task Force considers the evidence about the benefits and harms of preventive services separately and equally. Data about harms are often obtained from observational studies because harms observed in RCTs may not be representative of those found in usual practice and because some harms are not completely measured and reported in RCTs.

Putting the body of evidence for all key questions together as a chain, the Task Force assesses the certainty of net benefit of a preventive service by asking the 6 major questions listed above. The Task Force would rate a body of convincing evidence about the benefits of a service that, for example, derives from several RCTs of screening in which the estimate of benefits can be generalized to the general primary care population as "high" certainty (see the "Rating Scheme for the Strength of Recommendations" field). The Task Force would rate a body of evidence that was not clearly applicable to general practice or has other defects in quality, research design, or consistency of studies as "moderate" certainty. Certainty is "low" when, for example, there are gaps in the evidence linking parts of the analytic framework, when evidence to determine the harms of treatment is unavailable, or when evidence about the benefits of treatment is insufficient. Table 4 in the methodology document listed below (see "Availability of Companion Documents" field) summarizes the current terminology used by the Task Force to describe the critical assessment of evidence at all 3 levels: individual studies, key questions, and overall certainty of net benefit of the preventive service.

Sawaya GF et al., Update on the methods of the U.S. Preventive Services Task Force: estimating certainty and magnitude of net benefit. Ann Intern Med. 2007;147:871-875.[5 references].

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

What the United States Preventive Services Task Force (USPSTF) Grades Mean and Suggestions for Practice

Grade	Grade Definitions	Suggestions for Practice
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer or provide this service.
B	The USPSTF recommends the service. There is high certainty	Offer or provide this service.

Grade	Grade Definitions	Suggestions for Practice
	that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.	
C	The USPSTF recommends against routinely providing the service. There may be considerations that support providing the service in an individual patient. There is moderate or high certainty that the net benefit is small.	Offer or provide this service only if there are other considerations in support of the offering/providing the service in an individual patient.
D	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.	Discourage the use of this service.
I Statement	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality or conflicting, and the balance of benefits and harms cannot be determined.	Read the "Clinical Considerations" section of USPSTF Recommendation Statement. If the service is offered, patients should understand the uncertainty about the balance of benefits and harms (see "Major Recommendations" field).

USPSTF Levels of Certainty Regarding Net Benefit

Level of Certainty*	Description
High	The available evidence usually includes consistent results from well-designed, well-conducted studies in representative primary care populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly affected by the results of future studies.
Moderate	The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by factors such as: • The number, size, or quality of individual studies • Inconsistency of findings across individual studies • Limited generalizability of findings to routine primary care practice • Lack of coherence in the chain of evidence As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion.
Low	The available evidence is insufficient to assess effects on health outcomes. Evidence is insufficient because of:

Level of Certainty*	Description
	• The limited number or size of studies • Important flaws in study design or methods • Inconsistency of findings across individual studies • Gaps in the chain of evidence • Findings not generalizable to routine primary care practice • A lack of information on important health outcomes More information may allow an estimation of effects on health outcomes.

*The USPSTF defines certainty as "likelihood that the USPSTF assessment of the net benefit of a preventive service is correct." The net benefit is defined as benefit minus harm of the preventive service as implemented in a general, primary care population. The USPSTF assigns a certainty level based on the nature of the overall evidence available to assess the net benefit of a preventive service.

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Comparison with Guidelines from Other Groups
Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Peer Review. Draft recommendations were circulated for comment from reviewers representing professional societies, voluntary organizations and federal agencies. These comments were discussed before the whole U.S. Preventive Services Task Force before final recommendations were confirmed.

Recommendation of Others. Recommendations for counseling to prevent tobacco use from the following groups were considered: the American Academy of Family Physicians, the American College of Obstetricians and Gynecologists, and the American College of Preventive Medicine.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The US Preventive Services Task Force (USPSTF) grades its recommendations (A, B, C, D, or I) and identifies the Levels of Certainty regarding Net Benefit (High, Moderate, and Low). The definitions of these grades can be found at the end of the "Major Recommendations" field.

Summary of Recommendations and Evidence

The USPSTF recommends that clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products. **This is a grade A recommendation**.

The USPSTF recommends that clinicians ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling for those who smoke. **This is a grade A recommendation**.

Clinical Considerations

Patient Population Under Consideration

This recommendation applies to adults 18 years or older and all pregnant women regardless of age. The USPSTF plans to issue a separate recommendation statement about counseling to prevent tobacco use in nonpregnant adolescents and children.

Counseling Interventions

Various primary care clinicians may deliver effective interventions. There is a dose-response relationship between quit rates and the intensity of counseling (that is, more sessions or longer sessions improve quit rates). Quit rates seem to plateau after 90 minutes of total counseling contact time. Helpful components of counseling include problem-solving guidance for smokers (to help them develop a plan to quit and overcome common barriers to quitting) and the provision of social support as part of treatment. Complementary practices that improve cessation rates include motivational interviewing, assessing readiness to change, offering more intensive counseling or referrals, and using telephone "quit lines."

Treatment

Combination therapy with counseling and medications is more effective at increasing cessation rates than either component alone. Pharmacotherapy approved by the U.S. Food and Drug Administration and identified as effective for treating tobacco dependence in nonpregnant adults includes several forms of nicotine replacement therapy (gum, lozenge, transdermal patch, inhaler, and nasal spray), sustained-release bupropion, and varenicline.

Useful Resources

Detailed reviews and recommendations about clinical interventions for tobacco cessation are available in the U.S. Public Health Service Clinical Practice Guideline, "Treating Tobacco Use and Dependence: 2008 Update" (available at www.surgeongeneral.gov/tobacco/).

Tobacco-related recommendations from the Centers for Disease Control and Prevention's Guide to Community Preventive Services are available at www.thecommunityguide.org/tobacco/index.html.

Other Considerations

Implementation

Strategies that have been shown to improve rates of tobacco cessation counseling and interventions in primary care settings include implementing a tobacco user identification system; providing education, resources, and feedback to promote clinician intervention; and dedicating staff to provide tobacco dependence treatment and assessing the delivery of this treatment in staff performance evaluations.

Definitions:

What the United States Preventive Services Task Force (USPSTF) Grades Mean and Suggestions for Practice

Grade	Grade Definitions	Suggestions for Practice
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer or provide this service.
B	The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.	Offer or provide this service.
C	The USPSTF recommends against routinely providing the service. There may be considerations that support providing the service in an individual patient. There is moderate or high certainty that the net benefit is small.	Offer or provide this service only if there are other considerations in support of the offering/providing the service in an individual patient.
D	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.	Discourage the use of this service.
I Statement	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality or conflicting, and the balance of benefits and harms cannot be determined.	Read the "Clinical Considerations" section of USPSTF Recommendation Statement. If the service is offered, patients should understand the uncertainty about the balance of benefits and harms (see "Major Recommendations" field).

USPSTF Levels of Certainty Regarding Net Benefit

Level of Certainty*	Description
High	The available evidence usually includes consistent results from well-designed, well-conducted studies in representative primary care

Level of Certainty*	Description
	populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly affected by the results of future studies.
Moderate	The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by factors such as: • The number, size, or quality of individual studies • Inconsistency of findings across individual studies • Limited generalizability of findings to routine primary care practice • Lack of coherence in the chain of evidence As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion.
Low	The available evidence is insufficient to assess effects on health outcomes. Evidence is insufficient because of: • The limited number or size of studies • Important flaws in study design or methods • Inconsistency of findings across individual studies • Gaps in the chain of evidence • Findings not generalizable to routine primary care practice • A lack of information on important health outcomes More information may allow an estimation of effects on health outcomes.

*The USPSTF defines certainty as "likelihood that the USPSTF assessment of the net benefit of a preventive service is correct." The net benefit is defined as benefit minus harm of the preventive service as implemented in a general, primary care population. The USPSTF assigns a certainty level based on the nature of the overall evidence available to assess the net benefit of a preventive service.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is not specifically stated for each recommendation.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Effectiveness of Interventions to Change Behavior

- In nonpregnant adults, the U.S. Preventive Services Task Force (USPSTF) found convincing evidence that smoking cessation interventions, including brief behavioral counseling sessions (<10 minutes) and pharmacotherapy delivered in primary care settings, are effective in increasing the proportion of smokers who successfully quit and remain abstinent for 1 year. Although less effective than longer interventions, even minimal interventions (<3 minutes) have been found to increase quit rates.
- The USPSTF found convincing evidence that smoking cessation decreases the risk for heart disease, stroke, and lung disease.
- In pregnant women, the USPSTF found convincing evidence that smoking cessation counseling sessions, augmented with messages and self-help materials tailored for pregnant smokers, increases abstinence rates during pregnancy compared with brief, generic counseling interventions alone. Tobacco cessation at any point during pregnancy yields substantial health benefits for the expectant mother and baby. The USPSTF found inadequate evidence to evaluate the safety or efficacy of pharmacotherapy during pregnancy.

USPSTF Assessment

- The USPSTF concludes that there is high certainty that the net benefit of tobacco cessation interventions in adults is substantial.
- The USPSTF also concludes that there is high certainty that the net benefit of augmented, pregnancy-tailored counseling in pregnant women is substantial.

POTENTIAL HARMS

Harms of Interventions

Finding no published studies that describe harms of counseling to prevent tobacco use in adults or pregnant women, the U.S. Preventive Services Task Force (USPSTF) judged the magnitude of these harms to be no greater than small. Harms of pharmacotherapy are dependent on the specific medication used. In nonpregnant adults, the USPSTF judged these harms to be small.

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- The U.S. Preventive Services Task Force (USPSTF) makes recommendations about preventive care services for patients without recognized signs or symptoms of the target condition.
- Recommendations are based on a systematic review of the evidence of the benefits and harms and an assessment of the net benefit of the service.
- The USPSTF recognizes that clinical or policy decisions involve more considerations than this body of evidence alone. Clinicians and policy-makers should understand the evidence but individualize decision making to the specific patient or situation.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The experiences of the first and second U.S. Preventive Services Task Force (USPSTF), as well as that of other evidence-based guideline efforts, have highlighted the importance of identifying effective ways to implement clinical recommendations. Practice guidelines are relatively weak tools for changing clinical practice when used in isolation. To effect change, guidelines must be coupled with strategies to improve their acceptance and feasibility. Such strategies include enlisting the support of local opinion leaders, using reminder systems for clinicians and patients, adopting standing orders, and audit and feedback of information to clinicians about their compliance with recommended practice.

In the case of preventive services guidelines, implementation needs to go beyond traditional dissemination and promotion efforts to recognize the added patient and clinician barriers that affect preventive care. These include clinicians' ambivalence about whether preventive medicine is part of their job, the psychological and practical challenges that patients face in changing behaviors, lack of access to health care or of insurance coverage for preventive services for some patients, competing pressures within the context of shorter office visits, and the lack of organized systems in most practices to ensure the delivery of recommended preventive care.

Dissemination strategies have changed dramatically in this age of electronic information. While recognizing the continuing value of journals and other print formats for dissemination, the Agency for Healthcare Research and Quality will make all U.S. Preventive Services Task Force (USPSTF) products available through its Web site. The combination of electronic access and extensive material in the public domain should make it easier for a broad audience of users to access U.S. Preventive Services Task Force materials and adapt them for their local needs. Online access to U.S. Preventive Services Task Force products also opens up new possibilities for the appearance of the annual, pocket-size *Guide to Clinical Preventive Services*.

To be successful, approaches for implementing prevention have to be tailored to the local level and deal with the specific barriers at a given site, typically requiring the redesign of systems of care. Such a systems approach to prevention has had notable success in established staff-model health maintenance organizations, by addressing organization of care, emphasizing a philosophy of prevention, and altering the training and incentives for clinicians. Staff-model plans also benefit from integrated information systems that can track the use of needed services and generate automatic reminders aimed at patients and clinicians, some of the most consistently successful interventions. Information systems remain a major challenge for individual clinicians' offices, however, as well as for looser affiliations of practices in network-model managed care and independent practice associations, where data on patient visits, referrals, and test results are not always centralized.

IMPLEMENTATION TOOLS

Foreign Language Translations
Patient Resources
Personal Digital Assistant (PDA) Downloads
Pocket Guide/Reference Cards

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

U.S. Preventive Services Task Force. Counseling and interventions to prevent tobacco use and tobacco-caused disease in adults and pregnant women: U.S. Preventive Services Task Force reaffirmation recommendation statement. Ann Intern Med 2009 Apr 21;150(8):551-5. [7 references] PubMed

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

1996 (revised 2009 Apr)

GUIDELINE DEVELOPER(S)

United States Preventive Services Task Force - Independent Expert Panel

GUIDELINE DEVELOPER COMMENT

The U.S. Preventive Services Task Force (USPSTF) is a federally-appointed panel of independent experts. Conclusions of the U.S. Preventive Services Task Force do not necessarily reflect policy of the U.S. Department of Health and Human Services (DHHS) or its agencies.

SOURCE(S) OF FUNDING

United States Government

GUIDELINE COMMITTEE

U.S. Preventive Services Task Force (USPSTF)

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

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**This list includes members of the Task Force at the time this recommendation was finalized. For a list of current Task Force members, go to www.ahrq.gov/clinic/uspstfab.htm..*

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

The U.S. Preventive Services Task Force has an explicit policy concerning conflict of interest. All members disclose at each meeting if they have an important financial conflict for each topic being discussed. Task Force members with conflicts can participate in discussions about evidence, but members abstain from voting on recommendations about the topic in question.

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: U.S. Preventive Services Task Force (USPSTF). Counseling to prevent tobacco use and tobacco-caused disease: recommendation statement. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2003 Nov. 13 p.

GUIDELINE AVAILABILITY

Electronic copies: Available from the U.S. Preventive Services Task Force (USPSTF) Web site and the Annals of Internal Medicine Web site.

Print copies: Available from the Agency for Healthcare Research and Quality (AHRQ) Publications Clearinghouse. For more information, go to http://www.ahrq.gov/news/pubsix.htm or call 1-800-358-9295 (U.S. only).

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

Background Articles:

- Barton M, et al. How to read the new recommendation statement: methods update from the U.S. Preventive Services Task Force. Ann Intern Med. 2007;147:123-127.
- Guirguis-Blake J, et al. Current processes of the U.S. Preventive Services Task Force: refining evidence-based recommendation development. Ann Intern Med. 2007;147:117-122. [2 references]
- Sawaya GF, et al. Update on the methods of the U.S. Preventive Services Task Force: estimating certainty and magnitude of net benefit. Ann Intern Med. 2007;147:871-875. [5 references].

Electronic copies: Available from U.S. Preventive Services Task Force (USPSTF) Web site.

The following are also available:

- Counseling and interventions to prevent tobacco use and tobacco-caused disease in adults and pregnant women: clinical summary of U.S. Preventive Services Task Force recommendation statement. Rockville (MD): Agency for Healthcare Research and Quality, 2009. Electronic copies: Available from the U.S. Preventive Services Task Force Web site.
- The guide to clinical preventive services, 2008. Recommendations of the U.S. Preventive Services Task Force. Rockville (MD): Agency for Healthcare Research and Quality (AHRQ), 2008. 249 p. Electronic copies available in English and Spanish from the AHRQ Web site. See the related QualityTool summary on the Health Care Innovations Exchange Web site.

Print copies: Available from the Agency for Healthcare Research and Quality Publications Clearinghouse. For more information, go to http://www.ahrq.gov/news/pubsix.htm or call 1-800-358-9295 (U.S. only).

The Electronic Preventive Services Selector (ePSS), available as a PDA application and a web-based tool, is a quick hands-on tool designed to help primary care clinicians identify the screening, counseling, and preventive medication services that are appropriate for their patients. It is based on current recommendations of the USPSTF and can be searched by specific patient characteristics, such as age, sex, and selected behavioral risk factors.

PATIENT RESOURCES

The following are available:

- Men: stay healthy at any age. Your checklist for health. Rockville (MD): Agency for Healthcare Research and Quality. AHRQ Pub. No. 07-IP006-A. February 2007. Electronic copies: Available from the USPSTF Web site. See the related QualityTool summary on the Health Care Innovations Exchange Web site.
- Women: stay healthy at any age. Your checklist for health. Rockville (MD): Agency for Healthcare Research and Quality. AHRQ Pub. No. 07-IP005-A. February 2007. Electronic copies: Available from the USPSTF Web site. See the related QualityTool summary on the Health Care Innovations Exchange Web site.

Print copies: Available in English and Spanish from the Agency for Healthcare Research and Quality (AHRQ) Publications Clearinghouse. For more information, go to http://www.ahrq.gov/news/pubsix.htm or call 1-800-358-9295 (U.S. only).

The following is also available:

- Quit smoking: consumer interactive tool (PDA/Palm). Rockville (MD): Agency for Healthcare Research and Quality (AHRQ); 2004. Downloads are available from the AHRQ Web site.

Myhealthfinder is a new tool that provides personalized recommendations for clinical preventive services specific to the user's age, gender, and pregnancy status. It features evidence-based recommendations from the USPSTF and is available at www.healthfinder.gov.

NGC STATUS

This summary was completed by ECRI on June 30, 1998. The information was verified by the guideline developer on December 1, 1998. This summary was updated by ECRI on November 12, 2003. The information was verified by the guideline developer on November 13, 2003. This summary was updated by ECRI Institute on November 6, 2007, following the U.S. Food and Drug Administration advisory on Antidepressant drugs. This NGC summary was updated by ECRI Institute on April 23, 2009. The updated information was verified by the guideline developer on June 16, 2009. This summary was updated by ECRI Institute on July 20, 2009 following the U.S. Food and Drug Administration advisory on Varenicline and Bupropion.

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